

**PHIP Steering Committee
June 21, 2004
Tacoma, WA
Sheraton Hotel**

Attendance:

Janice Adair
Jean Baldwin
Sherri Bartlett
Joan Brewster
Janet Charles
Ed Dzedzy
Larry Fay
Ed Gray
Sue Grinnell
Marie Flake
Maxine Hayes
Patty Hayes
Ward Hinds
Wendy Holden
Larry Jecha
Gordon Kelly
Vicki Kirkpatrick
Kay Koontz

Mary Looker
Craig McLaughlin
Rick Mockler
Suzanne Plemmons
Alice Porter
Terry Rundell
Donna Russell
Rita Schmidt
Mary Selecky
Torney Smith
Lois Speelman
Jack Thompson
Jude VanBuren
Greg Vigdor
Mary Ann Welch
Frank Westrum
Jack Williams

Special Guest: Jan Malcom, Robert Wood Johnson Foundation

Introductory Remarks:

Mary Selecky, for Department of Health, Larry Fay, for WSALPHO, and Craig McLaughlin, for State Board of Health, provided opening remarks, emphasizing that this was an opportunity to provide guidance to key questions brought before the Steering Committee by each PHIP Committee.

Special Guest Jan Malcom from Robert Wood Johnson Foundation was introduced. She has become familiar with this work and welcomed the opportunity to see the Partnership in action.

Notes on Committee Reports

The following reports are summaries of points taken from each discussion table and summarized by Committee chairs at the end of each report segment.

Key Health Indicators

Questions:

- Shall we have a report card with a grading system, using letter grades?
 - Letter grades are okay.
 - Letter grades are easy to communicate, but can be difficult to characterize, so we need to be sure that the meaning of a letter grade is stated clearly.
 - Keep values consistent for numbers that support the grade. For example, make sure that we have a footnote so we can tell whether a high number is always good, and low is always bad.
 - Make sure rankings are tied to a standard indicator, not another state.
 - Need to decide where we want to be rather than use an inappropriate comparison.
 - Consider grading against high goals such as HP2010 rather than grading on the curve. Set the bar high for all areas.
 - Where we use national data, we should get the best data we can get, i.e., 2010, BRFSS. This may have problems in use, but we should get the best data we can.
- Where health disparities exist, shall we lower the state's grade?
 - Important to highlight disparities - but need to message this correctly.
 - Need to write clear messages about health disparities, otherwise many people understand that for some populations, we are not doing very well.
 - The meaning could be lost if it was incorporated into a letter grade.
 - Need to remember that in the past, the population of the state was very homogenous – need to make sure whatever grade we give, it is reflective of the changing population.
 - Show them – but find a more effective symbol. Could use the + – with the disparities notations.
- Shall we add a plus or minus sign to signify trends?
 - Use arrows to show direction of trend; some concern about confusing the audience with the + or - trends
 - Knowing the trend is important.
 - Make it simple – don't make it too complicated.
 - Make sure we market and communicate it appropriately and give out careful information to explain the grades. Consult with King County.

Update: The Action Guide to be placed on web. It will serve as a resource to guide people to helpful sites to learn about health indicators and interventions that work.

Standards

- Should our approach be more rigorous in the next measurement?
 - The next measurement assessment should be more in-depth, although looking at every standard in every area may not be realistic.
 - We need a more accurate report of performance, yet we also need to also be comparable to last time. Can we construct it to do both?
 - Recognize that it will take time and money to do a complete assessment.
 - Consider doing the assessment in rounds, for example, Environmental Health one year, Disease Protection the following year, etc.
 - Show how programs have improved across the board.
 - We need to hold ourselves to a higher standard than before.
 - We could use a matrix similar to DOH for each local health department, but the question is how far to go with that.
 - We need to improve in documentation.
- To establish accountability, should the Standards be linked in some way to funding? Should accreditation be explored further?
 - Are the standards voluntary or mandatory? If voluntary, it will much more difficult to find the funds or support to do it. However, if it is not tied to funding, no one will do it.
 - Tying standards to funding won't work if we take away funding for not meeting standards but it might work if we use funding as an incentive to meet the standards.
 - Tying accreditation or funding to standards at this time could hurt LHJs because their funds are being cut.
 - We should link standards to accreditation or funding only if there is a new funding source. We do not want to lose LCDF flexibility to improve the standards.
 - Standards are reflective of what is already being done and where we need to improve. We need to be cautious about attaching funding (new or old) to standards.
 - For local health standards, it is a delicate balancing act because it is very difficult to make improvements. There needs to be more effort in bringing everyone up to the same level. If we look more rigorously we will see that we need more money.
 - If Standards are tied to funding, does that mean that those doing poorly get more money? We have concern about tying funding to Standards, if we are not ready. We need to ratchet up the performance first. If the

Standards are about quality performance – they may or may not tie to funding.

- Accreditation should be explored further. It is intriguing. It should be done only by people trained and experienced in the process.
- Comment from Mary Selecky: From national perspective, we need to work to improve because there may be a national effort to impose standards on us through an accreditation process. How well are we positioned to say we are doing our own processes? What happens to a health department that doesn't get accredited? The idea of accreditation needs to be explored with commissioners.
- Should we continue to use an outside evaluator?
 - It is important to use an outside evaluator.
 - Yes we need them. We are paying a low cost for a lot of work.
- Update: Administrative capacities to be pilot tested.

Finance

The proposed model for calculating the costs of meeting the Standards was presented to the Steering Committee.

- Do you understand the model?
 - The model is logical and assumes that all the elements are being done. The estimates used the number of people it would take to do the service. It is important to understand how the estimates were developed and the fact that they were checked with real health department estimates that will then be scaled.
 - Some believe small counties will say the model does not apply to them. Some feel the model is a qualitative approach to make something look quantitative. Others say we only need to make it good – not perfect. Some say where we are now is better than we have ever been in terms of understanding costs.
 - It is important to document clearly the assumptions used. We must show there is "soundness" to our model. Be clear about qualitative assumptions used to calculate the number. It is difficult to tell where the FTEs already exist or are missing. It is important to understand where the gaps are.
 - The biggest challenge will be to describe what more people or policy makers will get for the increased funding -- what they are "buying". We need to be

prepared to answer questions like "if we give you 50% of what you are asking, how will you spend it?"

- We must be able to describe what they are buying as a package and be prepared to break the package apart.
- We must show one big number for the whole system but be prepared to describe the total number in a variety of ways (e.g., per capita, as a percentage of current PH spending, as a percentage of personal health care spending, as the return on investment, etc.)
- Some members were concerned that if we break out the cost by topic area it will lead to "special interest" funding. Others believed that it is important to break it out by topic area so the policymakers can have an opportunity to work with it, identify priorities, etc.
- Sometimes services in a community are not provided by the health department. Make sure know where the services are being delivered.
- We need to talk about strategies--where we go from here.
- Question: Should we be funding the gap or buying an outcome?
 - It is important to understand where the gaps are and translate that into outcomes.
 - The money we say we need will be a big number, but we should not be afraid of a big number. It is miniscule compared to the whole health care system.
 - It is important to emphasize the opportunity for prevention and promotion. However, local government is not responsive to costs of prevention and promotion. We need to look at other ways of funding public health and determine who funds which piece.
 - It is important to explain what the money will buy. We should be marketing public health to meet the Standards at the highest level.

Workforce Development

Results of the workforce survey Everybody Counts were described.

An update explained that that two priority areas were selected for establishing learning goals. These were 1) New Coalitions and Alliances, strengthening community mobilization and systems thinking approaches, and 2) Results-based Accountability, strengthening quality improvement efforts and strategic planning skills. These were seen

as two ways we could work across jurisdictions to foster development of a learning-oriented culture in public health.

- Question: Do you support recommendations to foster a learning culture in these ways? Should we explore these further?
 - These make sense, but we also really need to work on leadership development.
 - Given the complexity of demand on public health, constituency development may be too soft.
 - Recruitment and Retention needs serious, formal attention. WSALPHO needs to develop a strong program with this as a goal.
 - Agree that attention to systems thinking is important so that workers begin to see the world and their jobs as inter-related to community efforts. Public health has tended to be too insular, and needs to broaden its contacts.
 - Quality improvement is also important and needs to be seen in the context of performance measurement.
 - We could use training in supervision and coaching. As budgets are cut, many people move into positions where these become their job roles, whether or not they are prepared for them.
 - We really need to develop specific training plans: who needs what, related to their job roles.
 - We don't have to develop everything new. We should become adept at gathering what is out there.

Information Technology

This was an update on current activities including PHIMS and a discussion about whether we should sponsor an "IT Summit" bringing county health officials and IT staff together with county IT people, so that they could, collectively, see some of the system wide trends and emerging needs.

- Generally a good idea. We need administrators involved in discussion of the overall vision, in addition to making sure the right people have an understanding of the technical requirements.

- There are many different approaches: some have autonomy about IT decisions and some don't. Some buy directly from vendors while others have to go through elaborate approval processes.
- A summit might be a way to match up areas with needs – with areas that have already found solutions to those needs.
- There is some fear that if we try to set standards and organize our approach, we might create something far too complex to sustain. There is something to be said for innovation and adoption of new ideas once they are working.
- There are many topics that merit system wide discussion and direction: wireless technology, standard business functions, minimum requirements for the desktop.
- Establishing “Public Health Washington” as a basic technical framework might be a good idea.

Communications

This was a presentation about the communications campaign and a discussion about next steps. Some of the main ideas discussed: How do we get to a bigger message? Who does the talking – who are effective spokespeople? We need to look for speakers at local level. We need to tell our story and to become very good storytellers.

- Question: What ideas or advice do you have?
 - Make communications a priority. Add as a standing agenda item to PH meetings how we are going to communicate to all 35 LHJs any messages, changes, etc., being decided in the meetings.
 - Look outside for others in the community or state to be champions for public health and help communicate the PH messages.
 - Seeing the logo everywhere does not mean that the message is being heard or understood. We should evaluate how well the message is being integrated within a system or organization.
 - Maybe part of the message should be to ask, "what do you need from public health" rather than telling people what public health is doing for you.
 - What catches people's attention are the stories. Consider working with a storytelling consultant to learn how to tell a good story. Jack Thompson suggested Andy Goodman.

- Are we training internally so that everyone knows the PH messages? A cheat sheet (hard copy) for all public health employees that is widely distributed would be good. It is very difficult to find things on the website.
- Examples of how to use the tools successfully would be good. Such as:
Publications- Skagit County – organized their annual report around the materials... Used in a report to Board of Health...An agency walk, wearing t-shirts... bumper stickers... Maybe there should be T-shirts at all events across the state.
- We need to imbed into voters mind the importance of public health work, starting with local boards and our workforce. We need simple tools that help us get this done and stories and pictures that illustrate what we do.
- Need a baseline and then polling to see if we are making progress or improving. Promote good news from any poll.

Access

The Co-Chairs fro this activity presented a meeting plan timetable and ideas about the PHIP recommendations for the Committee on Access to take into consideration.

- A preliminary committee will be formed and begin to meet between June and October, 2004. They will develop a Committee charge, scope of wok and membership. The Committee meetings will be held by December.
- Between January and March, 2005, the group will consider producing a white paper on access issues from a public health perspective.
- During spring 2005, the group will also consider expanding the menu of critical health services and will collect and describe models of effective community planning around access to health services.